Summary Report of the HB 248 Work Group

Submitted to the Governor and the Chair of the Senate Committee on Education and Health and the Chair of the House of Delegates Committee on Health, Welfare and Institutions, pursuant to Chapter 646, Acts of Assembly – 2022 Session

November 1, 2022

COMMONWEALTH OF VIRGINIA

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November 1, 2022

Transmitted via Email

The Honorable Glenn Youngkin
Governor of Virginia

The Honorable L. Louise Lucas, Chair
Committee on Education and Health
Senate of Virginia

The Honorable Robert D. Orrock, Sr., Chair
Committee on Health, Welfare and Institutions
Virginia House of Delegates

Dear Governor Youngkin, and Chairs Lucas and Orrock:

Chapter 646, Acts of Assembly – 2022 Session (HB 248), directed the State Corporation Commission, Bureau of Insurance, to convene a stakeholder work group to provide input into the development of the methodology to measure and evaluate the efficiency and productivity of insurance carriers, managed care health insurance plans and health care providers; identify additional measures to increase the transparency of information provided to the Bureau by these entities; and identify additional information these entities should provide to the designated nonprofit organization to foster transparency and competition among both carriers and health care providers and assist consumers in making educated decisions regarding options for health care coverage and access. This report represents the perspectives of the participating stakeholders.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

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Introduction

Chapter 646 (the Act) of the 2022 Acts of Assembly (House Bill 248), included in this report as Appendix A, requires the Department of Health, in consultation with the State Corporation Commission, Bureau of Insurance (Bureau), to establish a methodology to measure and evaluate the efficiency and productivity of insurance carriers, managed care health insurance plans and health care providers.

The purposes of the Act are to: (i) foster transparency and competition among carriers and health care providers and (ii) provide information on the Virginia Health Information (VHI) website at VHI.org. Virginia Health Information is the nonprofit organization described in § 32.1-276.4 of the Code of Virginia that assists consumers in making educated decisions about options for health care coverage and access.

The Bureau convened a stakeholder group to begin the work outlined in the Act. The group included Delegate Glenn R. Davis – the bill patron – and representatives from:

Virginia Department of Health
Virginia Health Information
Virginia Association of Health Plans
Virginia Hospital and Healthcare Association
Medical Society of Virginia
Virginia Health Benefit Exchange
Mercer, representing employers

While the Bureau and VHI staffed and facilitated the stakeholder group, this summary represents the perspectives of the participating stakeholders.

Stakeholder Group Meetings

The first meeting was held on August 29, 2022. Delegate Davis explained that his intent in sponsoring House Bill 248 was to have an easily understood dashboard of certain health care data that brings transparency and comparability to consumers on a website maintained by VHI.

The stakeholder group determined the following scope of work:

- Identify a central location to make the health care information available to consumers or other interested parties.
- Identify how to provide currently available data to consumers and other interested parties on one website.
- Have the data reporting efforts focus on the fully insured commercial market regulated by the Bureau, consisting of comprehensive medical insurance for Individual, small, and large group markets.
- Have the provider focus be on hospital and physician groups and not delve into many of the ancillary health care professions.

Information Necessary to Comply with the Act

Entities represented by the Virginia Hospital and Healthcare Association and the Virginia Association of Health Plans provide most of the currently available information filed with either the Bureau, the Virginia Department of Health, or VHI and published on one of their websites. VHI can accommodate the statutory requirements of providing the data in one location on VHI.org. Also, VHI will create dashboards utilizing currently reported data without the need for additional funding until such time as additional data requests are potentially designed and implemented that expand the current scope.

The stakeholder group discussed whether or not the currently reported information desired by the parties is in sufficient detail regarding health plans and providers of health care to be of use. The stakeholder group also discussed information that is currently available only in an aggregated format and what may need to be provided for each health plan, facility, provider, etc., with the sentiment that similar information should be required from both health plans and providers.

The stakeholder group identified initial performance measures for the dashboard based on three categories:

- Measures that can be developed using data immediately available and useful in its current format;
- Measures using data that would either need to be reported in a more detailed format, a new format, or collected in a data call; and
- Measures using data elements that are neither currently collected nor available in any format but that could be included in future dashboards.

In its second meeting on September 26, 2022, the Virginia Hospital and Healthcare Association and the Virginia Association of Health Plans provided lists of measures that included at least five elements based on currently available data that could be drawn into a single usable format to comply with the provisions of the statute. Several of the identified items were only available in an aggregate format and would require new, granular collection on a going-forward basis to meet the described need. The complete lists are shown in Appendix B.

Recommendations

The stakeholder group identified the following data elements that should be implemented in VHI's July 1, 2023, dashboard. This data will be beneficial to consumers and important for transparency:

- Health plan premium rates, including changes over time – by health plan, by region, including average premium per member per month, with a 5-year comparison detail for individual and small group markets. (Category: Spending/Costs, Source: Bureau);

- Health plan averages and ranges of deductibles and averages and range of cost sharing, including changes over time - by health plan with a 5-year comparison

detail for individual and small group markets. (Category: Spending/Costs, Source: Bureau);

- Health plan medical loss ratios, including changes over time – by health plan with a 5-year comparison detail for individual and small group markets. (Category: Profit/Expense Margin, Source: Bureau);

- Health plan NCQA star ratings – by health plan with a 5-year comparison detail, as available in the necessary detail for reporting on the market level. (Category: Quality, Source: National Committee for Quality Assurance - NCQA);

- Number of health plans per region for individual and small group fully insured markets. (Category: Choice and Competition, Source: Bureau);

- Information on hospitals in region by ownership. (Category: Choice and Competition, Source: VHI);

- Hospital total margin, operating margin, and percent spending for care versus administrative (to the extent available). (Category: Profit/Expense Margin, Source: VHI's current Hospital Efficiency dashboard); and

- Hospital readmission rates (as reported by the Centers for Medicare & Medicaid Services (CMS) under the Hospital Readmissions Reduction Program (HRRP), VCHI low value care measures). (Category: Quality, Source: VHI and CMS).

The stakeholders also agreed that definitions for the terms underlying several of the data elements are needed to help consumers understand the information presented in the dashboards. The work group will be engaged in assisting VHI with the definitions and presentation of the measures on the dashboard.

In addition to the primary recommendations, the stakeholders specifically request the Bureau to provide for publication of claim denial rates, complaint rates, and appeals filed on a plan and provider level (provider data is not currently available) and benefit category basis for future inclusion in the VHI dashboards. This measure would allow consumers to compare health plans and providers when researching coverage availability.

Implementation of these data elements in a central, consumer-friendly dashboard would meet the statutory requirements of the Act.

Continuation of the Work Group

The work group recommends that it remain in place and continue its work and meet at least quarterly to monitor the launch of the VHI dashboards and to develop new metrics over time. This would allow future consideration of more elements of choice and competition, profitability, quality, behavioral health access, spending/costs, and operational and performance measures for consideration after VHI publishes the dashboard on July 1, 2023.

APPENDIX A. 2022 Virginia House Bill 248

VIRGINIA ACTS OF ASSEMBLY -- 2022 SESSION

CHAPTER 646

An Act to require the Department of Health, through its contract with the nonprofit organization with which it enters agreements for certain data services, to develop and implement a methodology for evaluating the efficiency and productivity of carriers and managed care health insurance plans.

[H 248]

Approved April 11, 2022

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Department of Health (the Department), through its contract with the nonprofit organization described in § 32.1-276.4 of the Code of Virginia and in consultation with the Bureau of Insurance of the State Corporation Commission (the Bureau), shall by July 1, 2023, (i) develop and implement a methodology to review and measure the efficiency and productivity of health care providers and carriers, as defined in § 38.2-3407.10 of the Code of Virginia, other than limited scope dental or vision plans licensed pursuant to Chapter 45 (§ 38.2-4500 et seq.) of Title 38.2, and managed care health insurance plans, as defined in § 38.2-5800 of the Code of Virginia and certified by the Department pursuant to § 32.1-137.2 of the Code of Virginia, and (ii) make available to the public on a website maintained by the nonprofit organization such data and information and other reports collected or produced as a result of implementation of such methodology. The methodology shall be designed to foster transparency and competition among both carriers and health care providers and to assist consumers in making educated decisions regarding options for health care coverage and access.*

§ 2. The methodology described in § 1 shall:

1. Include provisions for comparisons of a specific carrier's or managed care health insurance plan's performance to (i) national and regional performance metrics for carriers or managed care health insurance plans, as appropriate, and (ii) other carriers or managed care health insurance plans, as appropriate;

2. Provide for the collection of data and information necessary to evaluate or compare (i) annual premium rates and changes to such rates over time; (ii) medical loss ratios and changes to such ratios over time; (iii) cost sharing levels and changes to such levels over time; and (iv) expenditures on inpatient hospital services, outpatient hospital services, emergency services, physician services, pharmaceuticals, and other major spending categories, and changes to such expenditures over time; and

3. Utilize data compiled by the Bureau and submitted to the nonprofit organization, data from data sources maintained by the Bureau and the Department, and other publicly available data sources.

Such methodology may include different methodologies for the assessment of various types of carriers and managed care health insurance plans.

§ 3. Any data submitted by the Bureau to the Department or the nonprofit organization in accordance with this act shall be provided in a secure manner to protect the safety and confidentiality of any proprietary information of any carrier or managed care health insurance plan.

§ 4. The Bureau shall convene a stakeholder work group composed of representatives of the Department, the nonprofit organization described in § 32.1-276.4 of the Code of Virginia, the Virginia Association of Health Plans, the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, and other such stakeholders as the Bureau deems appropriate to (i) provide input on the development of the methodology described in § 1; (ii) identify additional measures to increase the transparency of information provided to the Bureau by carriers, managed care health insurance plans, and health care providers; and (iii) determine what additional information should be provided to the nonprofit organization by carriers, managed care health insurance plan providers, and health care providers to foster transparency and competition among both carriers and health care providers and assist consumers in making educated decisions regarding options for health care coverage and access. The work group shall report its findings and recommendations to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022.

APPENDIX B. Statutory Party Data Lists for Consideration.

VHHA Submission - Plan Data

Item Prioritization	Plan Information To be Displayed on VHI	Information Availability	Current Data Source and Storage Location	Data Definition, if needed
1	Premium rate changes over time	CA	SCC BOI and CMS filings	Average premium, per member per month, tracked year over year. Initial publication should include at least a 4-year look back period. And data need to be at the market level (individual, small group, large group).
2	Medical Loss Ratio (MLR) over time	CA	SCC BOI and CMS filings	MLR, tracked year over year, reported by plan type. Dashboard needs to include clear definitions of what included in the medical cost total and what is not. Optimally, the dashboard will allow a drill down into the categories within the medical costs (hospitals, drugs, etc.). Data need to be at the market level (individual, small group, large group). Initial publication should include at least a 4-year look back period.
3	Claims denial rates over time	CA	SCC BOI	Denial rates, by plan type (individual, small group, large group), by denial category. Denial categories have already been defined by the SCC BOI. And data need to be at the market level (individual, small group, large group). Initial publication should include at least a 4-year look back period.
4	Complaint rates over time	CA	SCC BOI	Complaints per 1,000 members per year filed against the carrier, by plan type (individual, small group, large group), by benefit category. The SCC BOI has already defined the benefit categories. Initial publication should include at least a 4-year look back period.
5	Appeals filed and results over time	CA	SCC BOI	Appeals filed and the appeal overturn rates per 1,000 members per year, by plan type (individual, small group, large group), by benefit category. The SCC BOI has already defined the benefit categories. Initial publication should include at least a 4-year look back period.
6	Actual cost share experience over time	PA	SCC BOI	The percentage of plan medical costs that were paid for directly by members (actual costs, NOT plan design amounts). Initial publication should include at least a 4-year look back period. And data need to be at the market level (individual, small group, large group).
7	Utilization of medical and pharmaceutical services, by category, on a per-member basis	NA	Carriers have the info	By plan type (individual, small group, large group). Initial publication should include at least a 4-year look back period.
8	Non-MLR spending by category	PA	SCC BOI	Expenditures (including profits), by category, for all costs not considered medical costs in the MLR calculation.
9	Average and median time to approve prior authorization requests over time	NA	Carriers have the info	By plan type (individual, small group, large group), the average and median amount of time that it takes carrier to issue a determination on a prior authorization request. Data sould be categorized by bebenfit category. Initial publication should include at least a 4-year look back period.
10	Average and median days to pay a claim from initial submission over time	NA	Carriers have the info	By plan type (individual, small group, large group), the average and median time to pay claims from the date of claim submission. This is for all claims. Initial publication should include at least a 4-year look back period.
11	CAHPS and QHP enrollee surveys by plan, as applicable	CA	SCC BOI and CMS	Member satisfaction information. Initial publication should include at least a 4-year look back period.
12	Percent of in-network providers that received payment in the measurement year, by provider type	NA	Carriers have the info	This is a proxy for assessing the robustness of access to care for members within a carrier's network.
13	Out-of-network payments as a percent of total claims payments, by provider type	NA	Carriers have the info	This is another measure of network adequacy.
14	Percent of claims not paid within the Virginia prompt pay requirements, over time	NA	Carriers have the info	By plan type (individual, small group, large group), the percent of all claims not paid within the required time to pay. The percent of claims that were deemed not "clean" should be specified. Initial publication should include at least a 4-year look back period.
15	Percent of total membership that used an out-of-network provider in the measurement year	NA	Carriers have the info	This is another measure of network adequacy.

VAHP Plan and Provider Measures

Area	Measure—Provider	Measure—Health Plan
Choice & Competition	Hospitals in region by ownership Hospital Ownership of: (1) primary care practices, (2) specialists (hospital only)	Number of Health Plans per region for individual, small group, and fully insured markets
Margin	Total Margin Operating Margin Percent spending for care v. administrative (hospital only)	MLR
Quality	Hospital Readmissions (hospital only) Use VCHI Low Value Care Measure(s)	Health plan star ratings
Mental Health Access	Inpatient BH admissions by voluntary and involuntary status (hospital only)	Percent BH providers in/out of network using MHPAEA classifications: IP, in network IP, out of network OP, in network OP, out of network
Spending/Costs	Cost and Price for spending categories such as prescription drugs, medical care, lab/imaging (hospital only)*	Premium Changes Avg deductible Avg cost-sharing

VAHP supports a series of initial measures that looks at choice and competition, profitability, quality, behavioral health access, and spending/costs. Table 1 outlines some potential measures in each of these areas for consideration. Those in highlighted in red text are already collected in other venues (e.g. VHI, VDH, or BOI) and should be easily collected for a dashboard.

Should we move forward with these initial measures, the next phase should focus on other key factors such as sites of care and utilization of services in each site setting by patient acuity.